MEDI-CAL UPDATE

Medical Services
Bulletin 352

Billing and Policy
General Medicine Bulletin 352 **November 2003**

Contents

OPT OUT

Articles with related Part 1 Manual Replacement Pages may be found in the "Program and Eligibility" bulletin. Articles with related Part 2 Manual Replacement Pages may be found in the "Billing and Policy" bulletin. The Medi-Cal Update *may not always contain a "Billing and Policy" section.*

Benefits Identification Card: Psychiatric Drugs Exclusion

Effective for dates of service on or after December 1, 2003, claims including the following psychiatric drugs do not require an issue date and may be billed with either the recipient's Social Security Number or BIC ID number:

Amantadine HCl
Amitriptyline HCl
Aripiprazole
Benztropine Mesylate
Biperiden HCl
Bupropion HCl
Buspirone HCl
Carbamazepine
Chlorpromazine HCl
Citalopram Hydrobromide
Clomipramine HCl
Clonidine HCl
Clozapine
Desipramine HCl
Diphenhydramine HCl
Divalproex Sodium
Donepezil HCl
Doxepin HCl
Escitalopram Oxalate
Fluoxetine HCl
Fluphenazine Decanoate
Fluphenazine HCl
Fluvoxamine Maleate
Gabapentin
Haloperidol
Haloperidol Decanoate
Haloperidol Lactate
Hydroxyzine HCl
Imipramine HCl
Isocarboxazid
Lamotrigine
Lithium Carbonate
Lithium Citrate
Loxapine Succinate
Mesoridazine Besylate
Mirtazapine
Molindone HCl
Nefazodone HCl
Olanzapine
Oxcarbazepine
Paroxetine HCl
Perphenazine
Phenelzine
Pimozide
Quetiapine Fumarate
Risperidone
Rivastigmine Tartrate
Sertraline HCl
Thioridazine HCl
Thiothixene
Topiramate
Tranylcypromine
Trazodone HCl
Trifluoperazine HCl
Trihexyphenidyl HCl
Valproate Sodium
Valproic Acid
Venlafaxine HCl
Ziprasidone HCl

The Department of Health Services (DHS) Medical Review Branch continues to issue replacement Medi-Cal Benefits Identification Cards (BICs) in an ongoing effort to nullify BICs that may have been stolen or misused. As a general safeguard, there is a claims payment requirement when determining recipient eligibility for use of all but select drugs and services. This claims payment requirement was outlined in the July 2003 *Medi-Cal Update* in an article titled "Benefits Identification Card: Billing Reminder" and is repeated as follows.

Please see **Benefits**, *page 2*

Benefits *(continued)*

When verifying eligibility for recipients who receive new cards, the Automated Eligibility Verification System (AEVS) will return the eligibility message, "For claims payment, current BIC ID number and date of issue required." Providers must have and use the BIC ID number and issue date from the new card when verifying recipient eligibility. All but excluded providers must have and use the BIC ID number and issue date from the new card when submitting claims for reimbursement. If the BIC ID number and issue date of the new card are not on the claim for recipients whose card returns the message, "Current BIC ID number and issue date required for payment," the claim will be denied.

The following provider types are not required to provide an issue date on the claim and may bill with either the recipient's Social Security Number or BIC ID number: Emergency Air Ambulance Transportation, Alternative Birthing Centers, Community Hospital Inpatient, Community Hospital Outpatient, County Hospital Inpatient, County Hospital Outpatient, Genetic Disease Testing, Emergency Ground Transportation, Certified Hospice, Long Term Care Facility and Mental Health Inpatient. For all other provider types, the ID number and issue date of the card must be placed on all claims, as follows:

- **Paper Claims:** Enter the BIC ID number in the *Insured's ID Number* field (Box 1A). Enter the issue date in the *Reserved For Local Use* field (Box 19) of the claim. Identify the issue date in the "mmddyy" format.

- **CALPOS Pharmacy Claims:** Enter the BIC ID number in the *Recipient ID* field. The issue date must be placed in the *Issue Date* field per the current *Medi-Cal Point of Service Network Interface Specifications* for CALPOS pharmacy claims.

- **Computer Media Claims (CMC):** Enter the BIC ID number in the *Recipient ID* field. The BIC issue date must be placed in the *Remarks* area. Left-justify and enter the words "BIC ISSUE DATE" and identify the issue date in the "mmddyy" format.

For assistance with eligibility, the Automated Eligibility Verification System (AEVS), Point of Service (POS) device or Medi-Cal Web site, www.medi-cal.ca.gov, call the POS/Internet Help Desk at 1-800-427-1295. If illegal use of a BIC is suspected, or if there are questions about this policy, call the Provider Support Center (PSC) at 1-800-541-5555.

24-Hour ECG Monitoring Codes: Benefit Update

Effective for dates of service on or after December 1, 2003, the following CPT-4 codes are reimbursable as Medi-Cal benefits for 24-hour electrocardiographic (ECG) monitoring:

- 93226 (electrocardiographic monitoring for 24 hours by continuous original ECG waveform recording and storage, with visual superimposition scanning; includes recording, scanning analysis with report, physician review and interpretation; scanning analysis with report)
- 93232 (electrocardiographic monitoring for 24 hours by continuous original ECG waveform recording and storage without superimposition scanning utilizing a device capable of producing a full miniaturized printout; includes recording, microprocessor-based analysis with report, physician review and interpretation; microprocessor-based analysis with report)

The updated information is reflected on manual replacement pages cardio 2 and 6 (Part 2) and tar and noncd9 2 (Part 2).

Gastric Suction Pumps: New HCPCS Code

Effective for dates of service on or after September 22, 2003, claims for gastric suction pumps must be billed with HCPCS code E2000 (gastric suction pump, home model, portable or stationary, electric). If providers obtained a *Treatment Authorization Request* (TAR) under a different procedure code, and provided the TAR after September 22, 2003, the TAR field office should be contacted to modify the procedure code on the TAR to be in agreement with the new code. *This information is reflected on manual replacement page medi non hcp 1 (Part 2).*

Prosthetic Implant: New Benefit

Effective for services on or after October 1, 2003, surgical providers may bill HCPCS code L8699 (prosthetic implant, not otherwise specified) for reimbursement of internal joint implants inserted during orthopedic procedures. Prior authorization is required. Code L8699 should be billed only if a more specific code is unavailable. *This information is reflected on manual replacement pages hcpcs ii 2 (Part 2) and surg 2 (Part 2).*

Podiatry Rate Adjustment

Effective for dates of service on or after July 1, 2003, reimbursement rates for podiatry office visit Evaluation and Management (E & M) services (CPT-4 codes 99201 – 99203 and 99211 – 99213) are equal to physician E & M reimbursement rates. Claims that have already been submitted for dates of service on or after July 1, 2003 will be automatically reprocessed.

Podiatry Services: Policy Update

Effective for dates of service on or after December 1, 2003, CPT-4 codes 11720 (debridement of nail[s] by any method[s]; one to five) and 11721 (…six or more) must be billed in conjunction with a primary diagnosis code indicating one of the following:

- A systemic disease or disorder of the feet that significantly impairs the ability to walk
- An infection to the toe, nail or foot

Claims for CPT-4 codes 11720 and 11721 must include ICD-9 code 110.1 (dermatophytosis of nail) as the secondary diagnosis code. A *Treatment Authorization Request* (TAR) is required.

Note: Claims for CPT-4 codes 11720 and 11721 must include the referring or treating provider's identification number in the *ID Number of Referring Physician* field (Box 17A) of the claim form.

This updated information is reflected on manual replacement page podi 5 (Part 2).

Non-Invasive Vascular Diagnostic Studies: Billing Limitations

Effective for dates of service on or after December 1, 2003, reimbursement for CPT-4 codes 93875 – 93888 and 93925 – 93979 (Non-Invasive Vascular Diagnostic Studies [NVDS]) is limited to three studies per 12-month period, per code, by any rendering provider, for the same recipient.

When the code frequency for NVDS is exceeded, a *Remittance Advice Details* (RAD) will be issued directing the provider to resubmit the claim with documentation of medical justification. A current history and physical, or a current progress note, that states the recipient's diagnosis and need for additional NVDS should be included with the claim. To further support the medical necessity, prior NVDS reports also should be submitted with the claim. *The updated information is reflected on manual replacement page medne non 1 (Part 2).*

Ultrasound Code Range: Correction

Current policy allows providers to perform an ultrasound prior to an induced abortion. This service may be reimbursed with CPT-4 codes 76801 – 76815 and 76817, when billed in conjunction with ICD-9 diagnosis codes 635 – 635.92, 637 – 637.92, 638 – 638.9 or V61.7. With the 2003 CPT-4 update, code 76816 (ultrasound, pregnant uterus, follow-up, per fetus) was incorrectly included within the range of acceptable CPT-4 codes, and has been removed. *This correction is reflected on manual replacement page abort 3 (Part 2).*

Hepatitis A and Hepatitis B Combo Vaccine: Billing Reminder

Providers are reminded that for dates of service on or after September 22, 2003, the hepatitis A and hepatitis B combination vaccine is reimbursable only when billed with CPT-4 code 90636. Providers who use HCPCS code X5346 on or after September 22, 2003 for this vaccine will be denied reimbursement. Refer to the *Injections* and *Vaccines for Children (VFC) Program* sections of the Part 2 provider manual for specific billing information about this vaccine.

Use of Modifiers: Billing Reminder

Up to four two-character modifiers may be entered in the modifier fields Box 24D of the *HCFA 1500.* All modifiers must be entered immediately after the procedure code. Information that overflows into other fields (especially additional modifier fields) will cause the claim to suspend and a *Resubmission Turnaround Document* (RTD) will be issued.

Specific modifiers identified in the billing instructions should be entered in the first modifier field.

When providers bill multiple modifiers for a service not specified in the Medi-Cal billing instructions as needing multiple modifiers, providers must follow existing Medi-Cal policy, and enter the specific modifier in the first modifier field. If the billing instructions require a service to be billed with a specified modifier, that modifier must be entered in the first field.

CHDP Gateway: Pre-Enrollment Reminder

Since July 1, 2003, Child Health and Disability Prevention (CHDP) program providers have been able to pre-enroll children in the Medi-Cal program using the new *Child Health and Disability Prevention (CHDP) Program Pre-Enrollment Application* (DHS 4073, revised 7/03) either on the Medi-Cal Web site (**www.medi-cal.ca.gov**) or through the Point of Service (POS) network. Children younger than 19 years of age who are pre-enrolled in Medi-Cal at the time of a CHDP health assessment are eligible to receive either full-scope, no-cost Medi-Cal benefits and dental coverage or CHDP and emergency Medi-Cal services for up to two months.

During a child's CHDP health assessment visit, a provider electronically submits pre-enrollment information and receives an immediate response indicating the child's eligibility status. An eligible child will receive coverage for up to two months (during the month of application and the subsequent month).

If a child is eligible for Medi-Cal benefits, a Benefits Identification Card (BIC) number is included in the eligibility response and the provider prints an Immediate Need Eligibility Document for the child from the Web site or POS device.

Any Medi-Cal provider can provide service to children presenting one of the documents below. Use the BIC number that appears on the document to verify eligibility for services such as office visits, optometric exams or prescriptions.


CHDP Gateway Pre-enrollment Application Response

CHDP GATEWAY PRE-ENROLLMENT RESPONSE

Provider Number : xxxxxxxx Application 07/01/2003 [illegible]

Patient's Name: Public John Q

Date of Birth: 01/01/1988

Gender: Male

BIC ID#: 1234567890

BIC Issue Date: 07/01/2003

Good Thru Date: 08/31/2003

You are temporarily eligible for Medi-Cal through 08/31/2003. Use this document to access Medi-Cal services until your benefits identification Card arrives. To continue your coverage, you must return a completed joint Healthy Families/Medi-Cal application before 01/31/2003. If you do not receive the application in the mail within 10 days, call 1-800-880-5305.

Client Signature: _____

Next Application Print

Sample (above). Immediate Need Eligibility Document via Medi-Cal Web site.


<Header Line #1>
CALIFORNIA
DEPARTMENT OF HEALTH SERVICES
MEDI-CAL POS NETWORK
<Header Line #5>

07/01/2003 12:04:22

TERMINAL: Y1234567890
SOFTWARE: ZZACHD1

PROVIDER NUMBER: CHA123456

CHDP GATEWAY
PRE-ENROLLMENT
RESPONSE

PATIENT NAME:
PUBLIC JOHN Q

DATE OF BIRTH:
1988-01-01

GENDER:
M

BIC ID#:
1234567890

ISSUE DATE:
2003-07-01

GOOD THRU DATE:
2003-08-31

YOU ARE TEMPORARILY ELIGIBLE FOR FULL SCOPE MEDI-CAL THROUGH 08/31/2003. USE THIS DOCUMENT TO ACCESS MEDI-CAL SERVICES UNTIL YOUR BIC ARRIVES. TO CONTINUE YOUR COVERAGE YOU MUST RETURN A COMPLETED JOINT HEALTHY FAMILIES/MEDI-CAL APPLICATION BEFORE 08/31/2003. IF YOU DO NOT RECEIVE THE APPLICATION WITHIN 10 DAYS, CALL 1-800-880-5305.

X _____
CLIENT SIGNATURE

<<SYSTEM MESSAGE(S) FROM >>
<< PROVIDER MAIL >>

THANK YOU!
<Footer 4>

Sample (right). Immediate Need Eligibility Document via POS device.

Please see **CHDP Gateway**, *page 6*

CHDP Gateway *(continued)*

Provider Assistance
For questions regarding POS or Internet requirements, contact the POS/Internet Help Desk at 1-800-427-1295, seven days a week, from 6 a.m. to midnight.

Please refer to the Medi-Cal Web site (**www.medi-cal.ca.gov**) for more information about the CHDP program. Providers who are interested in becoming CHDP providers can contact their local CHDP program. Please visit **www.dhs.ca.gov/chdp** for a list of local CHDP programs.

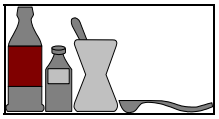
Medi-Cal Field Office: Address Change

Effective September 22, 2003, the San Francisco Medi-Cal Field Office address has changed, as follows:

San Francisco Medi-Cal Field Office (SFMCFO)
575 Market Street, Suite 400
San Francisco, CA 94105-2823

All telephone numbers remain the same. *Treatment Authorization Requests* (TARs) formerly sent to 185 Berry Street, Suite 290, should be sent to the new address.

This information is reflected on manual replacement pages tar field 9 (Part 2) and podi 2 (Part 2).



DRUG USE REVIEW
Educational Information

Vacancies for the Medi-Cal Contract Drug Advisory Committee and Drug Use Review Board

Medi-Cal has a unique opportunity for physicians and pharmacists to improve California's public health by serving on the Medi-Cal Contract Drug Advisory Committee (MCDAC) and the Medi-Cal Drug Use Review (DUR) Board. Medi-Cal has vacancies for the following:

- **One physician and one pharmacist on the Medi-Cal Contract Drug Advisory Committee (MCDAC)**

  The MCDAC provides expert advice to Medi-Cal in its evaluation of drugs for addition to the Medi-Cal List of Contract drugs. Committee members do most of their work by mail, with face-to-face meetings typically no more often than once a year. For information about the roles and responsibilities of this committee, go to:
  http://www.dhs.cahwnet.gov/mcs/mcpd/MBB/contracting/word/procedur.doc

- **Two pharmacist advisors on the Medi-Cal Drug Use Review (DUR) Board**

  The DUR Board has important influence on how drugs are used in California. By providing expert advice on policies set for Medi-Cal's prospective DUR system, and through analysis of data and educational programs, Medi-Cal's DUR Board members improve the health of Californians, while helping to control costs. Board members typically attend four meetings annually, either in Sacramento or by conference call. For more information about the roles and responsibilities of this board, go to:
  http://files.medi-cal.ca.gov/pubsdoco/dur/DUR_about.asp

Please see **Vacancies**, *page 7*

Vacancies *(continued)*

These positions are not salaried, but travel expenses are reimbursed. Here's a chance to make a difference!

Pharmacists and physicians interested in volunteering for either of these important committee positions can mail or e-mail their resumes and/or curriculum vitae to:

Linda Olsen
MSC 4604
P.O. Box 943732
Sacramento CA 94234-7320
E-mail: lolsen@dhs.ca.gov

Resumes may also be hand-delivered to:

Linda Olsen
Department of Health Services
MSC 4604
1501 Capitol Avenue, Room 71-3041
Sacramento, CA 94234-7320

Questions may be directed to Vic Walker at (916) 552-9500 or via e-mail at **vwalker@dhs.ca.gov**.

Medi-Cal List of Contract Drugs: Updates

The following provider manual section has been updated: *Drugs: Contract Drugs List Part 1 – Prescription Drugs* and *Drugs: Contract Drugs List Part 4 – Therapeutic Classifications.*

Additions, effective September 1, 2003

Drug	**Size and/or Strength**
PEGINTERFERON ALFA-2A	
* Injection	180 mcg/cc
* Restricted to use in the treatment of Hepatitis C. Also restricted to a maximum of four vials per dispensing and therapy lasting up to 48 weeks from the dispensing date of the first prescription.	
* Injection kit	180 mcg/cc
* Restricted to use in the treatment of Hepatitis C. Also restricted to a maximum of one convenience pack per dispensing and therapy lasting up to 48 weeks from the dispensing date of the first prescription.	

Please see **Contract Drugs**, *page 8*

Contract Drugs *(continued)*

Changes, effective September 1, 2003

Drug	**Size and/or Strength**
* RIBAVIRIN	
Capsules	200 mg
(NDC Labeler Code 00085 [Schering Corporation] only.)	
Tablets	**200 mg**
* Restricted to use as a combination therapy in the treatment of Hepatitis C. Also restricted to therapy lasting up to 48 weeks from the dispensing date of the first prescription.	

Changes, effective November 1, 2003

Drug	**Size and/or Strength**
CALCIUM ACETATE	
Tablets or capsules	667 mg
(NDC Labeler Code 59730 [Nabi] only.)	
* CEFDINIR	
Liquid	125 mg/5 cc
* ~~Restricted to use for individuals less than 8 years old.~~ **Prior authorization always required.**	
DESOGESTREL AND ETHINYL ESTRADIOL	
Tablets from 7/7/7 combination packet (28 tablets/packet)	7 x 0.100 mg/0.025 mg 7 x 0.125 mg/0.025 mg 7 x 0.150 mg/0.025 mg 7 x inert
(NDC labeler code 00052 [Organon, Inc.] only.)	
Payment limited to a minimum dispensing quantity of three cycles. See *California Code of Regulations* (CCR), Title 22, Section 51513(b)(4) regarding exceptions.	
ETHYNODIOL DIACETATE AND ETHINYL ESTRADIOL	
Tablets	1 mg – 35 mcg
	1 mg – 50 mcg
(NDC labeler code 00025 [Pharmacia and Upjohn] only.)	
Payment limited to a minimum dispensing quantity of three cycles. See *California Code of Regulations* (CCR), Title 22, Section 51513(b)(4) regarding exceptions.	

Please see **Contract Drugs**, *page 9*

Contract Drugs *(continued)*

Changes, effective November 1, 2003

Drug	**Size and/or Strength**
NEFAZODONE HCL	
Tablets	50 mg 100 mg 150 mg 200 mg 250 mg
(Labeler Code 00087 [Bristol-Myers Squibb Company] only.)	
NORETHINDRONE ACETATE AND ETHINYL ESTRADIOL	
Tablets	1 mg/5 mcg **1 mg – 20 mcg** **1.5 mg – 30 mcg**
Tablets from 5/7/9 combination packet (28 Tablets/packet)	**5 x 1 mg/20mcg** **7 x 1 mg/30mcg** **9 x 1 mg/35mcg** **7 inert**
(Labeler Code 00071 [Warner Lambert Company – Parke Davis] only.)	
NORETHINDRONE AND ETHINYL ESTRADIOL	
Tablets	0.4 mg – 35 mcg
(Labeler Code 00430 [Warner Chilcott Laboratories] only.)	
	1mg – 50 mcg
(Labeler Code 00430 [Warner Chilcott Laboratories] only.)	
Payment limited to a minimum dispensing quantity of three cycles. See *California Code of Regulations* (CCR), Title 22, Section 51513(b)(4) regarding exceptions.	
* OXANDROLONE	
Tablets	**10 mg**
* Prior authorization always required.	
***** PAPAIN-UREA-CHLOROPHYLLIN COPPER COMPLEX SODIUM	
Ointment	30 Gm 454 Gm
*** Prior authorization always required.**	

Please see **Contract Drugs**, *page 10*

Contract Drugs *(continued)*

Changes, effective December 1, 2003

Drug	**Size and/or Strength**
* AMPHETAMINE, MIXED SALTS (AMPHETAMINE SULFATE, AMPHETAMINE ASPARTATE, DEXTROAMPHETAMINE SULFATE AND DEXTROAMPHETAMINE SACCHARATE)	
Tablets	5 mg
	7.5 mg
	10 mg
	12.5 mg
	15 mg
	20 mg
	30 mg
(Labeler Code 54092 and 58521 [Shire US, Inc.] only.)	
LEVONORGESTREL AND ETHINYL ESTRADIOL	0.15 mg – 30 mcg
(NDC labeler code 50419 [Berlex Laboratories, Inc.] only.)	
Tablets from 6/5/10 combination packet	6 x 0.05 mg/30 mcg
	5 x 0.075 mg/40 mcg
	10 x 0.125 mg/30 mcg
(NDC labeler codes 00008 [Wyeth Laboratories] and 50419 [Berlex Laboratories, Inc.] only.)	
Payment limited to a minimum dispensing quantity of three cycles. See *California Code of Regulations* (CCR), Title 22, Section 51513(b)(4) regarding exceptions.	
NORETHINDRONE	
Tablets	0.35 mg
(Labeler Code 00062 [Ortho Pharmaceutical Corporation] only.)	
Payment limited to a minimum dispensing quantity of three cycles. See *California Code of Regulations* (CCR), Title 22, Section 51513(b)(4) regarding exceptions.	

Please see **Contract Drugs**, *page 11*

Contract Drugs *(continued)*

Changes, effective December 1, 2003

Drug	**Size and/or Strength**
NORETHINDRONE AND ETHINYL ESTRADIOL	
	0.5mg – 35 mcg
(Labeler Code 00062 [Ortho Pharmaceutical Corporation] only.)	
	1mg – 35 mcg
(Labeler Code 00062 [Ortho Pharmaceutical Corporation] only.)	
Tablets from 7/7/7 combination packet (21 Tablets/packet)	7 x 0.5 mg/35mcg 7 x 0.75 mg/35mcg 7 x 1.0 mg/35mcg
(Labeler Code 00062 [Ortho Pharmaceutical Corporation] only.)	
Tablets from 7/7/7 combination packet (28 Tablets/packet)	7 x 0.5 mg/35mcg 7 x 0.75 mg/35mcg 7 x 1.0 mg/35mcg 7 inert
(Labeler Code 00062 [Ortho Pharmaceutical Corporation] only.)	
Tablets from 10/11 combination packet (21 Tablets/packet)	10 x 0.5 mg/35mcg 11 x 1 mg/35mcg
(Labeler Code 00062 [Ortho Pharmaceutical Corporation] only.)	
Tablets from 10/11 combination packet (28 Tablets/packet)	10 x 0.5 mg/35mcg 11 x 1 mg/35mcg 7 inert
(Labeler Code 00062 [Ortho Pharmaceutical Corporation] only.)	
PAPAIN AND UREA Ointment	
(NDC Labeler Code 00064 [Healthpoint, LTD] only.)	

Laboratory Testing: Deletions and Restrictions

Effective for dates of service on or after December 1, 2003, CPT-4 codes 83001 (gonadotropin; follicle stimulating hormone [FSH]), 83002 (gonadotropin; luteinizing hormone [LH]) and 84146 (prolactin) will be updated to reflect the following reimbursement deletions and restrictions for Family PACT (Planning, Access, Care and Treatment) Program providers:

- CPT-4 code 83001 (FSH) will not be reimbursed in conjunction with primary diagnosis codes S101 – S102, S201 – S202, S301 – S302 and S701 – S702. In addition, code 83001 for primary diagnosis codes S901 – S902, is restricted to one test per year for the same recipient by the same provider.

- CPT-4 code 83002 (LH) will not be reimbursed by the Family PACT Program.

- CPT-4 code 84146 (prolactin) will not be reimbursed in conjunction with primary diagnosis codes S101 – S102, S201 – S202 and S301 – 302. In addition, code 84146, for primary diagnosis codes S901 – S902, is restricted to one test per year for the same recipient by the same provider.

Replacement pages for the *Family PACT: Policies, Procedures and Billing Instructions* (PPBI) manual will be issued in a future mailing to Family PACT providers. For more information about the Family PACT Program, please call the Provider Support Center (PSC) Hotline at 1-800-541-5555 (option "17") from 8 a.m. to 5 p.m., Monday through Friday, except holidays, or visit the Family PACT Web site at **www.familypact.org**.

Provider Orientation and Update Sessions

The Family PACT (Planning, Access, Care and Treatment) Program was established in January 1997 to expand access to comprehensive family planning services for low-income California residents.

To be eligible to enroll as a medical provider in the Family PACT Program, the Medi-Cal provider seeking enrollment is required to attend a Provider Orientation and Update Session. When a group provider wishes to enroll, a physician-owner must attend the session. When a clinic wishes to enroll, the medical director or clinician responsible for oversight of the medical services rendered in connection with the Medi-Cal provider number is required to attend.

Office staff members, such as clinic managers and receptionists, are encouraged to attend but are not eligible to receive a *Certificate of Attendance*. Currently enrolled clinicians and staff are encouraged to attend to remain up to date with program policies and services.

Note: Medi-Cal laboratory and pharmacy providers are automatically eligible to participate in the Family PACT Program without attending an orientation session.

Please see **Family PACT**, *page 13*

Family PACT *(continued)*

Dates and Locations

The following dates and locations are scheduled through February 2004:

November 19, 2003
Redding
Red Lion Hotel
1830 Hilltop Drive
Redding, CA 96002
For directions, call
(530) 221-8700

December 4, 2003
Riverside
Riverside Marriott
3400 Market Street
Riverside, CA 92501
For directions, call
(909) 784-8000

January 14, 2004
Yuba City
Best Western Bonanza Inn
1001 Clark Avenue
Yuba City, CA 95991
For directions, call
(530) 933-5209

February 24, 2004
Anaheim
Radisson Hotel Maingate
1850 South Harbor
Anaheim, CA 92802
For directions, call
(714) 750-2801

Check-in begins at 8 a.m. All orientation sessions start promptly at 8:30 a.m. and end by 4:30 p.m. The session covers Family PACT provider enrollment and responsibilities, client eligibility and enrollment, special scope of client services and benefits, provider resources and client education materials. This is not a billing seminar.

Provider Orientation and Update Session Registration

Providers should call the Center for Health Training at (510) 835-3795, ext. 113, to register for the session they plan to attend. Providers must supply the name of the Medi-Cal provider or facility, the Medi-Cal provider number, a contact telephone number, the anticipated number of people who will be attending and the location of the orientation session. At the session, providers must present their Medi-Cal provider number, medical license number and photo identification. Individuals representing a clinic or physician group should use the clinic or group Medi-Cal provider number, not the individual provider number or license number.

Completing the Provider Orientation and Update Session
Upon completion of the orientation session, each prospective new Family PACT medical provider will be mailed a *Certificate of Attendance*. Providers should include the white copy of the *Certificate of Attendance* when submitting the Family PACT application and agreement forms (available at the session) to Provider Enrollment Services.

Providers arriving late or leaving early will not be mailed a *Certificate of Attendance.* Currently enrolled Family PACT providers will not receive a certificate.

Family PACT Contact Information
For more information regarding the Family PACT Program, please call the Health Access Programs (HAP) Hotline at 1-800-541-5555 (option 17) from 8 a.m. to 5 p.m., Monday through Friday, except holidays, or visit the Family PACT Web site at **www.familypact.org**.

Instructions for Manual Replacement Pages
General Medicine (GM) Bulletin 352 November 2003

Part 2

Remove and replace:	abort 3/4
	cardio 1/2 and 5/6
	hcpcs ii 1/2
	medi non hcp 1/2
	medne non 1/2
	podi 1/2
Remove:	podi 5/6
Insert:	podi 5 thru 7 *(new)*
Remove and replace:	spec 5/6 *
	surg 1/2
	tar and non cd9 1/2
	tar field 9/10

* Pages updated due to ongoing manual updates